C+D

Chemist + Druggist
news education
www.chemistanddruggist.co.uk
9 February 2008

Postal strike and pricing error cost me £1,000

Building Bridges: industry says yes

Wholesaling: is there life after DTP?

- CPD: a picture guide to nail problems
- Ethics: a guide to registration for overseas pharmacists

A proposal

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CHAMPIX® Film-Coated Tablets (varenicline tartrate) **ABBREVIATED PRESCRIBING INFORMATION – UK. (See Champix Summary of Product characteristics for full Prescribing Information).** Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with *"Pfizer"* on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with *"Pfizer"* on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8 – End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment:* No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events:* Dosing may be reduced to 1 mg once daily. *Severe renal impairment.* 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease:* Treatment is not recommended. **Patients with hepatic impairm and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommend in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substar or to any of the excipients. **Warnings and precautions:** *Effect of smoking cessation;* Stopp smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, which dosage adjustment may be necessary (examples include theophylline, warfarin and insul Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smok cessation, with or without pharmacotherapy, has been associated with the exacerbation underlying psychiatric illness (e.g. depression). There is no clinical experience with Champi patients with epilepsy. At the end of treatment, discontinuation of Champix was associated v an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patie therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be u during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Chan should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driv and operating machinery:** Champix may have minor or moderate influence on the ability to d and use machines. Champix may cause dizziness and somnolence and therefore may influence ability to drive and use machines. Patients are advised not to drive, operate complex machi or engage in other potentially hazardous activities until it is known whether this medicinal pro

Pfizer

Date of preparation: November 2007 CHA354b

ELP THEM QUIT.[1-3]

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  - **Antagonist** action: Reduces the satisfaction associated with smoking†
- **Significantly higher quit rate vs. bupropion or placebo at 12 weeks**[1,2,5]
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† Based on the Minnesota Nicotine Withdrawal Scale (MNWS), Brief Questionnaire of Smoking Urges (QSU-brief) and modified Patient Evaluation Questionnaire (mCEQ).

s their ability to perform these activities. **Side-Effects**: Adverse reactions during clinical vere usually mild to moderate. Most commonly reported side-effects were abnormal dreams, nia, headache and nausea. Commonly reported side-effects were increased appetite, ilence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach nfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for less commonly reported ffects. **Overdose**: Standard supportive measures to be adopted as required. Varenicline has hown to be dialyzed in patients with end stage renal disease, however, there is no experience ysis following overdose. **Legal category:** POM **Basic NHS cost**: Pack of 25 11 x 0.5 mg l x 1mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1mg tablets Card (EU/1/06/360/004) . Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1mg tablets Bottle (EU/1/06/360/002) £54.60, Pack of 56 1mg tablets Card (EU/1/06/360/005) £54.60. l pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request**: Pfizer d, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 10/2007

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For further information, please contact Pfizer Medical Information on 01304 616161 or email medinfo.uk@pfizer.com

References: **1.** Gonzales D *et al.* JAMA 2006; 296:47-55. **2.** Jorenby DE *et al.* JAMA 2006; 296:56-63. **3.** Tonstad S *et al.* JAMA 2006; 296:64-71 **4.** Coe JW *et al.* J Med Chem 2005; 48:3474-3477. **5.** Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2. 6. CHAMPIX Summary of Product Characteristics.

CHAMPIX
varenicline tartrate

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Comment from the Editor

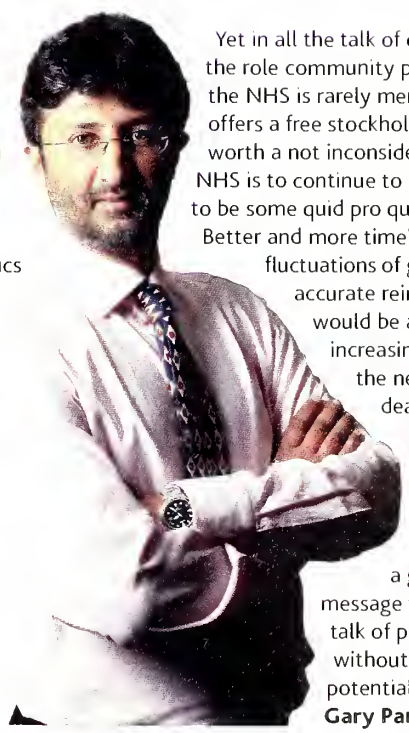
The full impact of last October's nightmare category M clawback has become all too apparent to pharmacy contractors.

A £400 million hit was never going to be easy to stomach, particularly when it was to be implemented in just one quarter. And for many, January's NHS income – despite ever-increasing prescription volumes – will barely cover their wholesale spend.

The comments expressed by contractors Dave Nickels of Newquay and David Croucher of the Isle of Wight (page 12) must surely indicate the pressure on the majority: "January's payment was farcical.... how can we plan for the future... I had to approach the bank with a humble cap in hand."

The roll out of the category M mechanism followed a protracted government investigation into the generics industry. It was designed to smooth out the pricing peaks and troughs and to bring stability. It was not expected to become the blunt instrument pharmacy contractors have experienced.

PSNC has taken the brunt of contractors' ire but, to be fair, it had flagged up the likelihood of a clawback. But with individual contractors unaware of how successful the sector is at purchasing as a whole, it could be argued those who monitor purchases nationally need to look at how they can better forewarn contractors of impending changes.



Yet in all the talk of overpayments and clawbacks, the role community pharmacy plays in supporting the NHS is rarely mentioned. The sector effectively offers a free stockholding service for the NHS – worth a not inconsiderable £8 billion – and if the NHS is to continue to benefit from this, there needs to be some quid pro quo.

Better and more timely monitoring of price fluctuations of generics, and quicker and more accurate reimbursement for pharmacy would be a start. A recognition of the increasing costs and bureaucracy that the new contracts and distribution deals have brought would be welcome too.

With C+D's campaign to get MPs talking to pharmacy gathering steam (pages 7 and 10), now would appear to be a good time to send a collective message to our paymasters. They often talk of pharmacy's potential but, without a sound financial base, that potential will never materialise.

Gary Paragpuri, Editor

Contents

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Penalised for postal strike delay

Contractor counts the cost after Royal Mail walk-out holds up delivery of September prescriptions to PPD

Emma Wilkinson/Max Gosney

A Worthing pharmacist has slammed NHS paymasters who left her £1,000 out of pocket due to an error caused by postal strikes.

Val Turner, of Turner Pharmacy, paid the penalty after Royal Mail walk-outs delayed delivery of her September 2007 prescriptions to the Prescription Pricing Division (PPD).

The PPD priced her prescriptions at reduced category M rates even though they had been filed before the £400 million cuts came into force last October.

Ms Turner said: "I feel really cross with the PPD. To apply October prices to September scripts shows a complete disregard for contractors."

Ms Turner said she only spotted the error by chance. "There's a very good chance I would not have seen it if it hadn't been for the fact we're looking to sell... so I'm looking at things a bit more closely."

The PPD is currently in the process of recalculating the pharmacy's payments, Ms Turner told C+D. A PPD spokesperson said it had contacted all contractors affected by postal strikes. "To date we have received three enquiries relating to these accounts and have acted to address any concerns that were raised."

PSNC claimed Ms Turner's case remained an isolated incident. A spokesman said: "The problem was caused by a localised postal strike ... no other contractors have reported to us that they have been affected in this way."

However, Ms Turner said she was "convinced there will be others" affected by the postal strikes and urged contractors to double check September payments.

Raw deal: Val Turner is convinced other contractors have been hit by the payment fiasco

Do you trust PPD to get payments right?
mgosney@cmpmedica.com

Contractor concerns lead to PPD inquiry

An investigation into the way the NHS handles exempt and paid prescriptions has been launched after contractors raised concerns over the process.

Nisheet Patel, of Cokeham Pharmacy in Sompting, West Sussex, claimed he had nearly 200 scripts in one payment switched from exempt to paid.

At the current prescription charge of £6.85, that amounts to a loss of more than £1,300 in a month. None had been switched the other way, Mr Patel added.

The NHS's Prescription Pricing Division (PPD) said its recently-introduced automated pricing system identified prescriptions' status more accurately than a manual process.

But it was investigating contractors' reports to ensure switches were correct, following a request from PSNC. The results of the investigation were expected next week, the PPD told C+D.

However, some contractors said a lack of communication about the effects of changes to the pricing system meant they had lost confidence in it. They urged others to be vigilant to variation in payments.

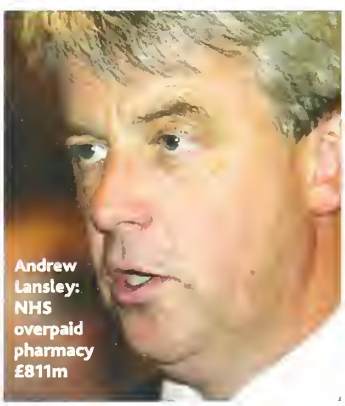
"If you don't check your invoices then you will never know," said Uma Patel of Dunns Chemist in Hounslow, London. "In my mind there are now serious doubts about the accuracy of reimbursements."

PSNC's National Prescription Research Centre is undertaking an independent audit of the new system. **JR**

PSNC squares up to Lansley

PSNC is pressing for a showdown with Andrew Lansley after the shadow health secretary accused the government of overpaying pharmacists £811 million.

The contract negotiator has invited Mr Lansley to meet representatives following a disagreement with the Conservative Party health spokesperson over purchase profits.



Andrew Lansley: NHS overpaid pharmacy £811m

Mr Lansley claimed government "incompetence" had cost the NHS £811m, earned by pharmacists between 2005 and 2007, in excess of the yearly £500m retained purchase profit in the contract.

But PSNC said Mr Lansley had failed to take into account the category M clawbacks designed to repay this excess. His claims were "extremely disappointing" and "quite erroneous", it said.

However, Mr Lansley stood by his comments. "The pharmacy contract has been incompetently managed by Labour ministers," he said. This included a lack of service commissioning.

"PSNC, on behalf of the pharmacy sector, should themselves be publishing this profit margin data and pressing for the original purposes of the pharmacy contract to be fulfilled." **JR**

Industry unites behind C+D's Building Bridges

Our aim to get more MPs into pharmacy has struck a chord right across the sector

Jennifer Richardson

Industry backing for C+D's Building Bridges campaign has flooded in since its launch last week (C+D, February 2, p7).

Messages of support for the campaign, which aims to get more politicians into pharmacies, came from across the sector.

Building Bridges aims to showcase the profession's potential and move it up the political agenda.

Numark's interim managing director, John D'Arcy, said the pharmacy group looked forward to educating MPs about the world of pharmacy. "I am very keen to encourage a dialogue between them [MPs] and independent pharmacists."

Multiple representatives also rallied behind the campaign cause. CCA & AIMp CEO Rob Darracott said: "The C+D campaign represents an important call to action at this crucial time in the development of pharmacy and the contract. We hope that lots of local pharmacists use this opportunity to talk to their MPs."

The campaign would help MPs understand that the role of pharmacists as simply medicine dispensers has changed, PSNC said. "Inviting your MP to visit... will help them to understand the vast and underutilised resource that pharmacy is," a spokesman said.

Messages of support

"This is about creating a strong voice for pharmacy and giving a strong message to policy makers that says: 'We can deliver better healthcare for our patients'."
Peter Gibson, head of public affairs, Alliance Boots

"Lloydspharmacy congratulates C+D on its Building Bridges campaign."
Andy Murdock, pharmacy director, Lloydspharmacy

"MPs and peers in both houses don't know how much pharmacy can do, so anything that informs them of what we're capable of is welcome."
Gopa Mitra, director of health policy & public affairs, PAGB

"AAH supports C+D's Building Bridges campaign. It is vital that elected representatives hear and see at first hand the important role which pharmacy plays and could play in delivering primary healthcare services."
Mark James, group managing director, AAH Pharmaceuticals

"I think this campaign is great. It will help educate MPs about the important role pharmacists play in the community."
Mike Holden, chief officer, Hampshire & Isle of Wight LPC

"I congratulate C+D on its campaign. The RPSGB is pleased to work in conjunction with the C+D team and its readers."
Jeremy Holmes, chief executive, RPSGB

More info at www.chemistanddruggist.co.uk/buildingbridges

Supporters also reminded pharmacists to use Building Bridges to emphasise the positives of the profession. "I think it's important not to come across as whingeing shopkeepers," said Graham Phillips, of Manor Pharmacy, Hertfordshire.

"What we want is for MPs to go back to Parliament and ask why we're not being commissioned."

For MPs' reactions, and to join our campaign, see p10

News in brief

Softer touch

The Royal Pharmaceutical Society has launched a consultation on relaxing disciplinary investigation criteria. The RPSGB wants its inspectorate to handle more minor cases rather than refer them to its formal investigating committee. www.rpsgb.org

Lloyds MD to quit

Justin Ash will step down as Lloydspharmacy managing director this June. Mr Ash will hand over to Richard Smith, chief operations and commercial director at the multiple, parent company Celesio said.

Estelle move

The Estelle range of HRT products has been transferred to Meda Pharmaceuticals, Pfizer has said. Pharmacists with queries should contact Meda – 0845460 0000 or Unidrug Distribution Group – 01773 510123.

Condom kiosks

Condom kiosks could be on their way to pharmacies under a £26.8 million Department of Health bid to improve access to contraception. The proposal was announced by minister for pharmacy Dawn Primarolo as C+D went to press. www.chemistanddruggist.co.uk

Smartcard guidance

PSNC has issued guidance on EPS smartcard renewal for pharmacists. http://tiny.cc/4ui2l

Wholesaler adds fuel surcharge

Record forecourt prices have forced introduction of fee, says Phoenix

Pharmacists have been hit with the first fuel surcharge on drugs deliveries as wholesalers feel the strain of record UK fuel prices.

Phoenix will charge a £9.75 monthly fee to contractors in response to 25 per cent rises in fuel costs compared to the same period in 2007. The move comes as average forecourt prices for petrol and diesel stay above £1 a litre.

Phoenix chief executive Paul Smith told C+D: "In any business it's difficult to absorb that kind of cost, but when you're expected to deliver twice a day it's even tougher."

Phoenix would remove the fee as soon as fuel prices dipped below the £1 level, Mr Smith said.

Rival wholesalers UniChem and Mawdsleys said they had no current plans to charge a fee. However, rising pump prices meant both firms were keeping a close eye on the situation.

The British Association of Pharmaceutical Wholesalers warned of fuel levies being charged to pharmacists last November. The BAPW has lobbied the DH over its concerns. **MG**

Money, money, money

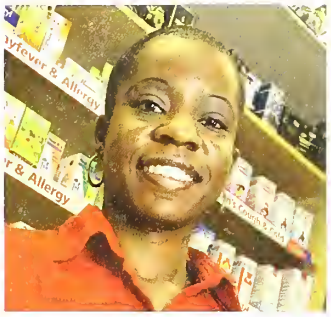
Worried your pay packet doesn't match up to that of your peers? Think you're not getting equal pay? Think you're being undercut by other locums? Want to know what the average pharmacist earns?

Fill in our C+D salary survey – the more entries there are, the better our results will be. Go to www.chemistanddruggist.co.uk – there is just one week left to take part. All information will be treated with the strictest confidence and we will publish anonymised, collated results.

£ Just a few days left to contribute to our salary survey.
Take part at: www.chemistanddruggist.co.uk

Dispensary TALK

What's the longest you've waited for an EPS download?



"This morning I scanned a prescription in and waited half an hour for it to download. That's the longest I've had to wait. It's not quick."
Jennifer Reid, Fairoak Pharmacy, Streatham, London

"Our system seems to be very efficient indeed. When we scan a prescription it takes 15 seconds maximum and it's downloaded."
Geoff Ray, Total Health Pharmacy, Watton, Norfolk

WEB VERDICT:

Up to 30 mins: 79%
Up to two hours: 5%
Up to five hours: 16%

Armchair view: Put your sleeping bags away – epic waits for electronic prescriptions to download appear to be rare according to our web poll. However, reports suggest the technology still moves at speeds more like Panda than Ferrari F40.

This week: Do you trust the PPA's new automated ordering system to get your payments right? Tell us at www.chemistanddruggist.co.uk

Scrap the Society and start again, inquiry told

New body could capture 'the imagination of the profession', says CCA

Emma Wilkinson

Scrap the Royal Pharmaceutical Society and start again, the UK's largest pharmacy firms have urged the inquiry into forming a new professional body.

The Company Chemists' Association said it did not "envisage the continuing existence of the Society" when it lost its regulatory role from 2010.

The Society could play a part within a future professional body, but the organisation must be "seen to be a fresh start", the CCA warned the Clarke Inquiry.

The CCA, whose members include Boots and Lloydspharmacy, said: "What is required now is a new beginning that captures the imagination of the profession."

The CCA also pointed out the lack of presence the Society had as a commentator on medicines issues. It said a future professional body needed to be influential and credible in order to give pharmacy a voice on the national stage.

"Pharmacists will want to join it because they recognise, in its leaders and vision, the values they aspire to," the CCA said.

The CCA comments came in a busy week for the Clarke Inquiry, an independent study into a professional body for pharmacy.

The Association of the British Pharmaceutical Industry said the profession was faced with a "once in a lifetime opportunity" to establish a new leadership body.

The ABPI said its call for a professional body stemmed from a struggle to find an effective joint working relationship with the Society because of its dual role as regulator and professional body.

The Pharmacists' Defence Association said a professional body should ideally be built from the remnants of the Society but that it must learn from the "mistakes of the past".

See the Clarke responses in full at www.chemistanddruggist.co.uk/news

Do we need a fresh start?
haveyoursay@cmpmedica.com

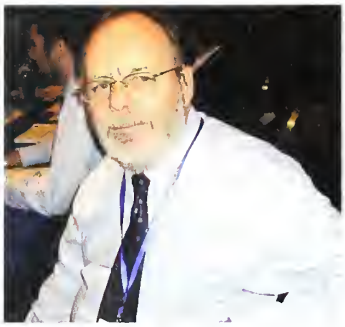
Men risk health online

Men too embarrassed to visit doctors are risking their health buying medicines online, experts said this week at the MHRA's annual conference in Birmingham.

Gift Minta, an MHRA intelligence analyst, said the internet could be "a shoulder to cry on" for many men. And Ian Banks, president of the Men's Health Forum, said drugs such as Viagra posed a particular problem as counterfeit levels were high, and self-medicating meant underlying conditions might not be diagnosed.

Dr Banks called for tougher policing of the internet and offered to join forces with the MHRA to achieve this. An MHRA spokesperson said the agency was looking into tactics such as flashing up warning messages on internet search engines when people look for drugs.

Priya Sejpal, RPSGB head of professional ethics, said men should not be discouraged from using legitimate internet pharmacies as they could be useful for people who would not normally visit them.


Ian Banks: offering a hand to the MHRA

The RPSGB last month launched a logo to help the public identify bona fide internet pharmacies. **ZS**

See next week's C+D for more on men and pharmacy

Ban on parallel trading lifted

A UK pharmacy has overturned a ban that prevented it parallel trading cut price drugs from Turkey to the lucrative US market.

The Appeal Court threw out a High Court injunction banning 8PM Chemists from trading medicines this week.

Drugs firm Lilly Icos Plc had won a court ruling last November to stop the firm exporting its drugs to the USA via Canadian internet pharmacies. The High Court had ruled Lilly Icos had a "good arguable case on infringement".

However, on appeal, 8PM argued that, as a matter of law, the impression given to US consumers cannot be relevant to the question of whether there is trademark infringement in the UK.

Lord Justice Jacob said: "The essential function of Lilly's European trademarks is in no way jeopardised by 8PM's activities." **UKL**

Is food intolerance slowing them down?

Find out with new Kymatika

Up to 45% of people have symptoms linked to food intolerance - headaches, fatigue, poor complexion, feeling bloated or just feeling below par. Unfortunately, most food intolerance testing systems are invasive, time-consuming and expensive.

Kymatika is different

Applying techniques from forensic science, Kymatika uses a test, based on the unique, infra-red, molecular 'fingerprint' of a food, to measure an individual's reaction to that food and identify current or potential problems right there and then. Kymatika has the 'fingerprints' of a wide range of foods on its database.

Offering this test will add value, and enhance the services that you currently provide to your customers. With minimal set up costs and training involved, you'll have the opportunity to realise profits of up to 60%.

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KYMATIKA™

Good for them, good for you

Bridging the gap

Building Bridges can put pharmacy on the political map, Jennifer Richardson reports

Sandra Gidley: grassroots visits will open MPs' eyes to pharmacy's potential

As far as Sandra Gidley is concerned, C+D's Building Bridges campaign could not have come at a better time.

The Building Bridges campaign aims to get as many politicians as possible into pharmacies to showcase the profession's potential and move it up the political agenda.

This sort of grassroots action is vital to helping those in power understand the sector, believes Ms Gidley, Liberal Democrat health spokesperson and a pharmacist. She says: "I don't think you can be fully aware of what pharmacy has to offer just by sitting in Whitehall and being told things. It's not real."

But the evidence suggests it just isn't happening. Dawn Primarolo, minister responsible for pharmacy, made just one pharmacy visit in her first four months in the post, a written ministerial answer to a question by Ms Gidley revealed (C+D, February 2, p7).

In total, health secretary Alan Johnson and his senior team made just five visits to pharmacies between June and November last year. Ms Gidley says: "The answer to the question highlighted an opportunity for greater engagement."

And Building Bridges is an ideal way to grasp that opportunity, she says, because issues raised with your local MP will filter up to Ms Primarolo and Mr Johnson. "If the MP visits take off, what you'll then have happening is MPs will take their concerns back to the ministers."

And Ms Gidley is confident that what they'll take back will benefit the profession. "[MPs] I know who've been to see a pharmacy have actually been very impressed," she says.

Ms Gidley's final word of advice is perseverance, even if your local MP seems reluctant to accept your invitation to visit your pharmacy. She says: "Keep inviting them – they can't refuse everything!"

Count on us... members of the devolved governments back Building Bridges

"It is important that members of the Scottish Parliament are kept up to speed with the work being done by pharmacies and that the channels of communication between the industry and parliamentarians are fully open. I very much look forward to visiting a community pharmacy in my own constituency and seeing at first hand the progress being made."
Stewart Stevenson, MSP for Banff and Buchan

"I think community pharmacies have got a lot to offer as part of the primary healthcare team, and I would urge support of the campaign. Since my visits I know more about what pharmacists can offer, and it's increased their enthusiasm to get involved in local campaigns and policy development in Wales."
Jeff Cuthbert, AM for Caerphilly, and founder and chair of the Welsh Assembly's all-party group on healthy living

"I think this campaign is a very good idea, particularly at this time when we are trying to get more active use of pharmacies. I think there is a poor understanding of the sector among politicians. For years we've underestimated the skills of pharmacists."
John McCallister, MLA (Ulster Union Party) and UUP Assembly Health Committee member

BUILDING BRIDGES

Yes please! I would like my MP to visit my pharmacy

The top three issues that I would like to raise with my MP are:

1. _____
2. _____
3. _____

Post to: Building Bridges, C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

Or fax to: 01732 367065

Or email: haveyoursay@cmpmedica.com

Your name: _____

Pharmacy name and address: _____

_____

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Postcode: _____

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For more information on the campaign see www.chemistanddruggist.co.uk/buildingbridges or contact C+D's news team on 01732 377315

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Each modified release tablet contains 800 mg mesalazine

℞ Asacol 800

by brand AND strength

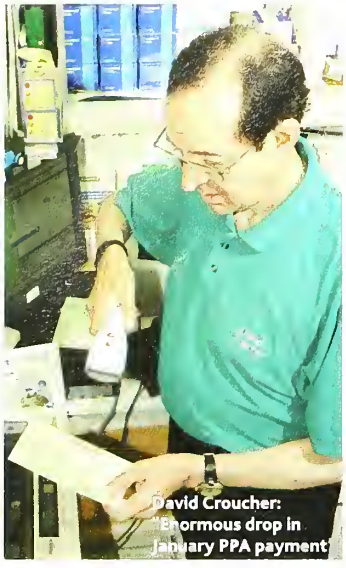
Asacol® 800mg MR Tablets Abbreviated Prescribing Information
Presentation: Asacol 800mg MR Tablets, PL 00364/0083, each modified release tablet contains 800mg mesalazine (5-aminosalicylic acid). Product is supplied in plastic (HDPE) bottles containing 180 tablets (£124.86). **Indications:** Ulcerative colitis: Treatment of mild to moderate acute exacerbations. For the maintenance of remission. Crohn's ileo-colitis: Maintenance of remission. **Dosage and administration:** Adults: Mild acute exacerbations: 3 tablets a day in divided doses. Moderate acute exacerbations: 6 tablets a day in divided doses. Maintenance of remission of ulcerative colitis and Crohn's ileo-colitis: Up to 3 tablets a day, in divided doses. **Elderly:** The normal adult dosage may be used unless renal function is impaired. **Children:** Not recommended. **Contra-indications:** A history of sensitivity to salicylates or renal sensitivity to sulfasalazine. Confirmed severe renal impairment (GFR less than 20 ml/min). Hypersensitivity to any of the ingredients. Severe hepatic impairment. Gastric or duodenal ulcer, haemorrhagic tendency. **Precautions:** Use in the elderly should be cautious and subject to patients having a normal renal function. Discontinue treatment immediately if acute symptoms of intolerance occur including vomiting, abdominal pain or rash. Patients with the rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine because of the presence of lactose monohydrate. Standard haematological indices (including the white cell count) should be monitored repeatedly in patients taking azathioprine, especially at the beginning of such combination therapy, whether or not mesalazine is prescribed. Asacol should be used in extreme caution in patients with confirmed mild to moderate renal impairment. Renal function should be monitored (with serum creatinine levels measured) prior to start of treatment, and periodically during treatment, taking into account individual history & risk factors. Mesalazine should be discontinued if renal function deteriorates. If dehydration develops, normal fluid & electrolyte balance should be restored as soon as possible. Serious blood dyscrasias (some with fatal outcome) have been very rarely reported with mesalazine. Haematological investigations including a complete blood count may be performed prior to therapy initiation and immediately if the patient develops unexplained bleeding, bruising, purpura, anaemia, fever or sore throat. Stop treatment if suspicion or evidence of blood dyscrasia. Lactulose or similar preparations which lower stool pH should not be concomitantly administered. Concurrent use of other known nephrotoxic agents, e.g. NSAIDs & azathioprine, may increase risk of renal reactions. Mesalazine should therefore be used with caution during pregnancy and lactation when the potential benefit outweighs the possible hazards in the opinion of the physician. If neonate develops suspected adverse reactions consideration should be given to discontinuation of breast-feeding or discontinuation of treatment of the mother. **Undesirable Effects:** Common: nausea, diarrhoea, abdominal pain, headache, vomiting, arthralgia/myalgia. Rare reports of leucopenia, neutropenia, agranulocytosis, aplastic anaemia, thrombocytopenia, myocarditis & pericarditis, peripheral neuropathy, vertigo, bronchospasm, eosinophilic pneumonia, pancreatitis, alopecia, lupus erythematosus-like reactions and rash (inc. urticaria), bullous skin reactions, abnormalities of hepatic function and hepatitis, interstitial nephritis and nephrotic syndrome with oral mesalazine treatment, usually reversible on withdrawal. Renal failure has been reported. Suspect nephrotoxicity in patients developing renal dysfunction. Drug fever. Very rarely, mesalazine may be associated with exacerbation of the symptoms of colitis. Stevens Johnson syndrome & erythema multiforme, interstitial pneumonitis. **Legal category:** POM. **Marketing Authorisation Holder:** Procter & Gamble Pharmaceuticals UK Ltd, Egham, Surrey TW20 9NW. Asacol is a trademark. © 2007 Procter & Gamble Pharmaceuticals. Refer to Summary of Product Characteristics before prescribing. Date of preparation November 2007 AS7555

Reference:
1. Asacol 800mg MR tablets Summary of Product Characteristics, September 2007

Date of Document Preparation January 2008. AS7609/55578.20

Adverse events should be reported to Procter & Gamble Pharmaceuticals UK Ltd on 01784 474900. Information about adverse event reporting can be found at www.yellowcard.gov.uk

Government policies crippling self-employed


David Croucher: 'Enormous drop in January PPA payment'

I consider myself to be running a successful and happy village pharmacy with an average month dispensing 3,200 FP10 items, and am a proud 'sole trader' with UniChem as my wholesaler. Its brand equalisation scheme for generics/gold standard product ethical lines has been my life blood for many years, yet even with its rebate scheme nothing could have prepared me for the enormous drop in my January PPA payment.

The great problem of course for us self-employed pharmacists is that one half of our annual income tax bill has to be paid by January 31. So the good old government gets us in the pocket from every direction!

This year, for the first time in my sole tradership, I had to approach the bank with a humble cap in hand and ask for an overdraft facility to cover the balance of my income tax cheque until my VAT rebate came through.

Imagine, my colleagues, the response we would get from the local petrol station if we went in tomorrow and told the proprietor that I was only going to pay 50p per litre because I felt he made a profit out of my car last autumn. I think the response would end in the word "off".

Reverend David Croucher, Niton Village Pharmacy, Isle of Wight

PSNC red herring distracts from true situation

I cannot let the comments of Sue Sharpe pass without clarification. PSNC has continually put forward this red herring of the ESPS or Local Pharmaceutical Service agreements (C+D, January 26, p6).

ESPS is a separate issue and will continue to be paid to pharmacies previously in receipt, albeit in a different form.

To those 'urban' pharmacies from whom the establishment fee will be removed as a result of the current remuneration model, the PCTs have made it abundantly clear that, on financial grounds, they cannot and will not be funding these pharmacies.

If PSNC can come up with any significant number of instances, in any of the major conurbations, where an 'urban' pharmacy will be funded by a PCT to replace loss of establishment fee then I will be astounded.

PSNC is also implying that most, if not all, affected pharmacies have significant income streams other than dispensing. This, in the case of the 30 or so independent pharmacies in Camden and Islington, is not the case. Most have a dispensing/OTC split in line with national norms for small pharmacies (say under 4,000ipm) without any other significant income stream.

The PSNC position may apply to city centre/major high street pharmacies but, largely, the affected Camden and Islington pharmacies do not fall into this category.

David Kent, chief executive officer, Camden & Islington LPC, London

Category M cut is devastating


News 2 February 2006
Cat M cuts hit contractor salaries

I totally agree with the headlines in the February 2 edition of C+D (p6).

January's payment was farcical... we knew that we would be hit hard after the category M announcements in October, and we had been very careful with our spend in the months after that announcement. But even so, we were devastated after receiving the January payment.

We had invested heavily in staff and equipment in the preceding months so we are ready for the implementation of electronic prescriptions and so we could improve and concentrate on our MUR service.

This underpayment throws a lot of plans into the melting pot again. Rather than invest for the future we are now worried about further clawbacks. How can we plan for the future when the Department of Health treats us with such contempt?

Dave Nickels, MyPharmacist.co.uk, Drury's Pharmacies, Newquay

Rotavirus vaccines under microscope

Dr Halvorsen uses incomplete information and alleges that the rotavirus vaccines have not been sufficiently investigated in his arguments against the introduction of rotavirus vaccination in the UK (C+D, January 26, p28).

There are two rotavirus vaccines that have been developed since the withdrawal of the first rotavirus vaccine Rotashield in 1999, to which Dr Halvorsen refers. Both vaccines have been the subject of extensive studies looking at safety, specifically including the risk of intussusception.

The development of GlaxoSmithKline's Rotarix involved one of the largest ever infant vaccine clinical trial programmes, based on data from 63,225 infants vaccinated with GSK's rotavirus vaccine. This analysis detected 25 cases of definite intussusception: nine of these were in vaccine recipients and 16 were in placebo recipients (p=0.16). In the absence of rotavirus vaccine, the rate of intussusception in the first year of life is between two and 10 children out of 10,000. The results from the safety analysis showed no significant difference in risk of occurrence of intussusception between the Rotarix and placebo groups.

The European Society for Paediatric Infectious Diseases and the European Society for Paediatric Gastroenterology, Hepatology and Nutrition announced European evidence-based recommendations on rotavirus vaccination last May, concluding that the vaccines were effective, had a good safety profile and could be used to control and prevent severe rotavirus gastroenteritis.

The US added a rotavirus vaccine to its recommended infant immunisations in 2006. Many other countries, including Austria, Australia, Mexico and Brazil, have also made rotavirus vaccination available. GSK believes that infants in the UK should be offered the same level of protection against this, the most common cause of gastroenteritis in children under the age of five.

Dr Richard South, vaccines medical director, GlaxoSmithKline UK

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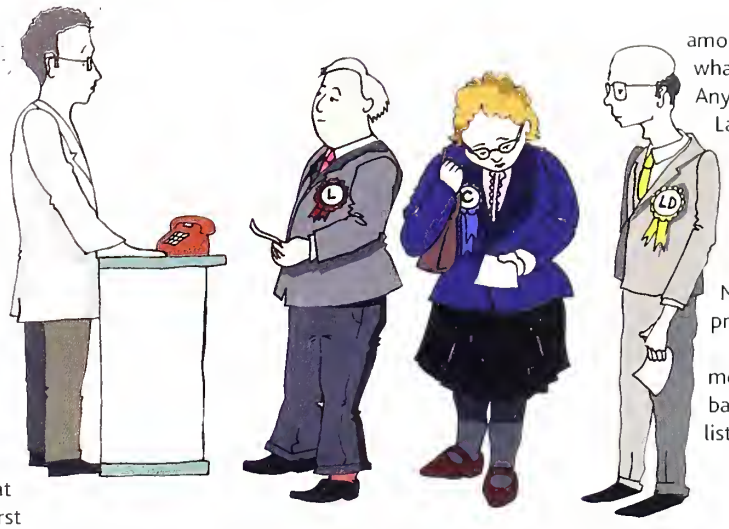
levomenthol

Xrayser

What are politicians really up to?



Cyril Smith once described the House of Commons as "the longest running farce in the West End". That's debatable but politicians certainly make entertaining, if at times uncomfortable, viewing.

Now that pharmacy is finally becoming a minority interest among MPs it's become even clearer how much hot air blows around the corridors of Westminster. The rumour that pharmacy could be used to both save the NHS money and improve its performance has got us mentions in a few official documents and minor speeches. But few seem to grasp what we're really about.

Shadow health secretary Andrew Lansley obviously hadn't checked his facts before making his headline-grabbing statement that we were "overpaid" by £811 million in the first two years of the contract (C+D, February 2, p7). I would be seriously worried if he ever got to be in charge of our monthly payments. PSNC has written to Mr Lansley to explain our reimbursement system.

C+D's Building Bridges campaign got off to a good start by revealing ministers know little about pharmacy because they rarely step inside one (C+D, February 2, p7). Health ministers made only four official visits to pharmacies during the second half of last year, compared to 39 visits to hospital wards. What more can the DH possibly need to know about the workings of a hospital ward? I can only see a few possible reasons for this discrepancy:

1. pharmacies and/or pharmacists are not considered photogenic enough
2. hospitals serve better tea and biscuits than pharmacies
3. the local hospital is closer to home than the local pharmacy
4. MPs aren't interested in pharmacy.

On a more positive note, Sandra Gidley has apparently done much to raise our profile among the decision makers. But what about the rest of her party? Anyone ever heard of Norman Lamb, the Lib Dem's shadow health secretary? I don't remember hearing him say the 'P' word in public. And I have no idea how the Lib Dem's party policy on health backs up Ms Gidley's support for the profession.

Let's hope that some of our most articulate and vociferous backers get along to Lord Darzi's listening events (C+D, February 2, p6) to help fill his fact file in support of our case.

Perhaps they can suggest he also makes a pharmacy visit because few practising pharmacists will be able to take a day off work to attend one of his events.

But let's get real. There must be some MPs who aren't in the tiny minority of the population who never visit a pharmacy. Forget the official visits, if they really want to know what pharmacy's all about, their local pharmacist will be delighted to fill them in next time they're collecting a prescription/buying some Calpol/asking for advice on a minor ailment.

No appointment necessary.

Pharmacist in the House — Sandra Gidley

Lend your support to this timely campaign

I had a meeting with Ara Darzi last week as he wanted to update me on the progress of his review.

I like the man and there is no doubt, in my very cynical mind, that he is sincere. There is a refreshing honesty about him and his answers to recent parliamentary questions demonstrate that someone forgot to book him on the 'how to avoid answering a difficult question' course. Long may it remain so but despite all of this I left the meeting feeling uneasy.

Much is expected of the Darzi review but it remains to be seen how the disparate work streams, at local and national level, are brought together. The problem is that the rest of the Department of Health appears to have succumbed to some kind of stasis – everything is on hold pending Darzi. While the aim to have some sort of joined up thinking in the Department of Health is very laudable, I'm not sure that this is great news for pharmacy.

We are all aware that a white paper, dealing with the future of pharmacy, is in the offing. What is less certain is that anyone, anywhere, has a clearly formed idea as to what the future holds for pharmacy. If they did, that vision is on hold pending the outcome of Darzi's review.

I have been told, but have yet to clarify, that there are few pharmacists involved in Darzi at local level. This will not be a surprise to anyone but it's not difficult to see that a medically dominated review will not be thinking hard about how to include pharmacy in the bigger picture.

The big problem is that whenever Lord Darzi is asked a detailed question the answer is usually along the lines of "that will be decided at a local level". This does not inspire confidence given the lack of understanding of pharmacy demonstrated by the average PCT.

> We have a disengaged minister and silence from Whitehall

In the meantime, community pharmacists are reeling from the impact of category M and struggling to get services commissioned at a local level. Our professional and regulatory body is about to split and this could not have come at a worse time as it diverts attention from the day-to-day matters affecting pharmacy.

We have a disengaged minister and silence from Whitehall. The C+D campaign could not have been more timely. I urge you to support it.

Sandra Gidley, Lib Dem MP and shadow health spokesperson

NPA provides training for 10,000 medicine counter assistants

The 10,000th student, Lydia Rossiter, medicines counter assistant at Woburn Sands Pharmacy, Milton Keynes was the recipient of a surprise bottle of champagne and flowers from Liam Stapleton, NPA Head of Education and Training.

Lydia Rossiter said: "The course was useful in increasing my knowledge of products and their effects on treatment. It also has given me more confidence talking to customers about medicines and identifying when the situation is more suitable to refer back to the pharmacist."

Usha Pan, Pharmacist and Lydia's tutor commented: "Lydia now has the skills to help our customers with advice about minor ailments and she's now an even more valuable member of the team."

Trevor Gore, Training and Development Manager, from Reckitt Benckiser said: "We believe in supporting pharmacy and the NPA Interact Course is one of the best ways to do this. It's proven that the course develops and increases the skills of pharmacy support staff."

Liam Stapleton, Lydia Rossiter and Trevor Gore

Reckitt Benckiser are proud to continue their support of NPA Pharmacy Interact

NPA Pharmacy Interact: Increase product knowledge for counter assistants

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To discuss further or to register a candidate please contact NPA Education & Training on 01727 800402 or email training.dept@npa.co.uk for more information. Please quote reference CD0902.

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C+D Clinical

Nailing the problem

A picture guide to some common nail problems and their treatment

Key points

- The nails can give clues to health:
  - clubbing can indicate lung disease
  - transverse ridges may appear after severe illness when nail growth stops temporarily
  - transverse white lines could indicate liver cirrhosis.
- Pharmacists can give advice on preventing problems such as in-growing toenails, and should be aware of the fungal nail infections that can be treated topically.

Reflect

What is the difference between onycholysis, onychogryphosis and onychomycosis? What would you recommend for a discoloured nail in which the colour does not appear to be growing out? When are topical antifungals appropriate for nails?

Plan

People may consult you about various marks on their nails. This illustrated guide will help you distinguish those that are harmless from those that need referral, and those for which you can give advice or OTC treatment.

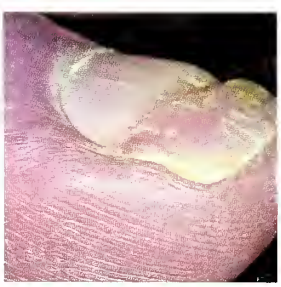
CPD This article can help in the following CPD competencies: **G1a, G1c, C1f, C3b**. See www.tinyurl.com/194zu

Dr Nigel Stollery

Finger and toenails are made of keratin. Their different regions include the nail plate, eponychium or cuticle, lanula and nail fold. They grow slowly – about 3mm a month – taking three to six months for a fingernail to re-grow fully.

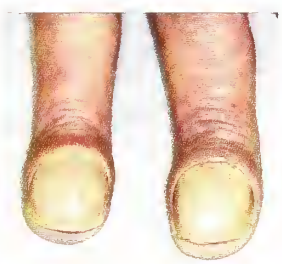
As well as protecting the ends of the digits, the nails give many clues to a person's health. Their colour, shape, texture and general appearance reveal underlying conditions such as anaemia and pulmonary disease.

Beau lines



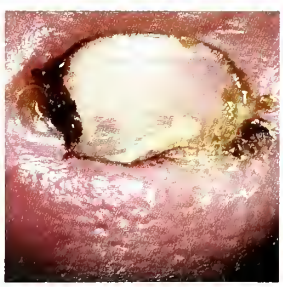
These occur as transverse ridges across the nails a few weeks after any severe illness, such as shock, myocardial infarction, sepsis, chemotherapy and severe skin disease. They usually appear on all the nails simultaneously as a result of a temporary halt in nail development in the matrix. They may also develop secondary to zinc deficiency. No treatment is necessary but it may take many months for the ridges to grow out.

Clubbing



In clubbing, or Hippocratic nails, the nails have an increased longitudinal curvature and loss of the normal 135° angle between the nail bed and the nail fold (called the Lovibond angle), thickening of the end of the fingers and fluctuation or softening of the nail bed. The condition takes many months to develop and is a marker of internal disease, such as chronic pulmonary disease, lung cancer, or heart disease such as cor pulmonale. In some cases it may be idiopathic and occur in younger people (this type tends to run in families). If a patient presents with clubbed fingernails it is worth asking how long they have been present and whether there is a family history. If the cause isn't known and the nails appear to have changed, they should be checked by a doctor. This is especially true if the person smokes, as this puts them at risk of heart or lung disease.

In-growing toenails



Pressure from poorly fitting shoes, poor pedicuring of nails and direct trauma can all produce in-growing toenails.

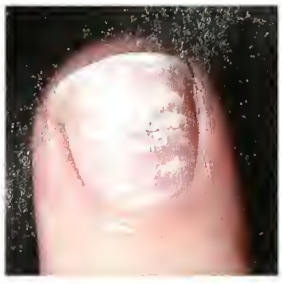
This is a localised inflammatory reaction, similar to the formation of a pyogenic granuloma, as the lateral edge of the nail pierces the adjacent skin. Once the skin is broken, entry of *Staphylococcus aureus* may produce localised infection increasing the pain. In-growing toenails are common but can be a challenge to treat. Regular soaking in warm salt water, meticulous attention to footwear, avoiding trauma, cutting the nail straight across (not down the side) and pressing cotton wool under the distal end to lift the nail away from the nail bed may all help. Referral to a chiropodist or, in the case of infection to a GP for antibiotics, may be required.

The College of Pharmacy Practice

This course (module 1429), in association with multiple choice questions being published in C+D March 1, provides one hour's continuing education

Need help with CPD? Visit C+D's clinical archive:
www.chemistanddruggist.co.uk/update

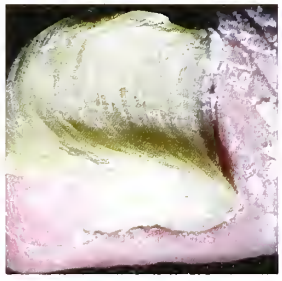
Leuconychia



Leuconychia are white spots in the nails. They are common and ignored by the majority of people. There is a long held belief that the condition is caused by calcium deficiency, however an association has never been proved. The cause is unknown but the appearance of white spots is often associated with trauma, which is thought to disrupt keratinisation of the nail as it forms. Recurrent multiple transverse white lines across the nail are called Muercke's lines. They are caused by hypoalbuminaemia and associated with liver cirrhosis.

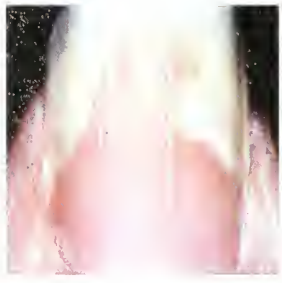
Reassurance is sufficient in most cases, but suspected cirrhosis should be referred.

Onychogryphosis



With increasing age, nails may become thicker and harder to cut. Decreased mobility and joint pain may also make care of the feet and nails more difficult, so nails may become dystrophic and unsightly. Patients should be referred to a podiatrist for cutting and debridement. This is especially important for people with diabetes who may have peripheral neuropathy, and those with poor circulation in whom healing will be slow if infection and trauma occur.

Onycholysis



This is the separation of the nail plate from the nail bed, producing a white or lighter discolouration beneath the nail. In almost all cases it starts distally and extends proximally down the length of the nail. One or all nails may be affected, including both finger and toe nails.

There are many causes but most cases are thought to be idiopathic. Many patients fear it is a fungal nail infection; this may be so in a few cases but only when there is nail dystrophy (deformity) and subungual hyperkeratosis (see onychomycosis below). Other more common causes are trauma, seen in those with long fingernails where repeated leverage lifts the nail away from the nail bed. Other causes include thyrotoxicosis, psoriasis, and prolonged immersion in water, which may be occupationally related. Drugs may also be responsible, particularly doxorubicin, bleomycin, captopril, 5-fluorouracil and retinoids. Other drugs, including tetracyclines, psoralens, fluoroquinolones and quinine, may cause photo-onycholysis when the nails are exposed to sunlight.

If the main presenting complaint is cosmetic, nail varnish can be applied to disguise the appearance. If trauma is felt to be contributory in long nails, advice should be given that unless the nails are cut the affected area may extend and the nails may drop off.

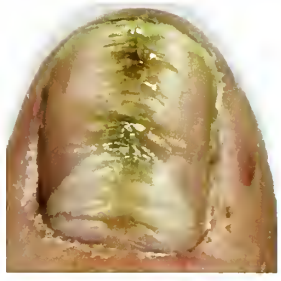
Onychomycosis

Caused in most cases by the fungus *Trichophyton rubrum*, onychomycosis is a common condition. Once established under the nail the fungus spreads laterally, penetrating the nail and travelling down towards the matrix. The nails become discoloured, dystrophic and brittle, separating from the nail bed. Keratin builds up under the nail bed giving the nails a thickened appearance. One or all nails may be affected, although toenails are more commonly affected than fingernails.

Antifungals are the treatment of choice, either topical or systemic. The topical forms work only for minor infection not involving the matrix. Anything beyond this should be referred to a GP, who is likely to take nail clippings and send them for mycology. If positive the treatment of choice is oral terbinafine once daily for three to six months, with accompanying liver function tests. The condition may recur after treatment is completed, and once aware of this many people opt to have no treatment, instead disguising the problem with nail varnish.

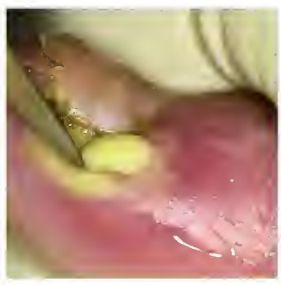
Onychotillomania

Habitual biting or manipulation of fingernails is a common preoccupation. Unlike other forms of tillomania such as trichtillo-mania (pulling out hair), which may be associated with depression and psychiatric illness, onychotillomania is no more than a bad habit. Where the nails are repeatedly bitten down, the exposed hyponychion swells at the fingertip. In other cases, repeated trauma to the proximal and lateral nail folds will deform the growing nail. In the photo, repeated trauma to the middle part of the proximal nail fold is called median nail dystrophy.



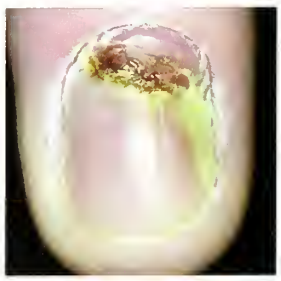
In all cases reassurance can be given that the deformity isn't the result of underlying disease and that the only way of returning the nails to normal will be to stop traumatising them. In most cases, this will be difficult to achieve.

Paronychia: acute



In this condition there is a sudden development of pain, redness and swelling of the lateral or posterior nail fold. The most important aetiological factor is a history of trauma, which is most commonly inflicted by picking or biting the nails. The causative organism is usually *Staphylococcus aureus*, which penetrates the area of trauma. In some cases pus may be visible at the surface, in which case the skin can be broken with a sterile needle and the pus expressed. The finger or toe can then be soaked in warm salty water. The area should be kept clean and dry and analgesia used if required. This may be enough to resolve the problem, but oral antibiotics may be required if the infection has not settled after a few days.

Paronychia: chronic



There is a history of chronic, red, tender swelling of the periungual tissue with an absence of cuticle. This leaves a direct communication between the exterior and the compartment below the proximal nail fold through which a variety of infections can penetrate, most commonly

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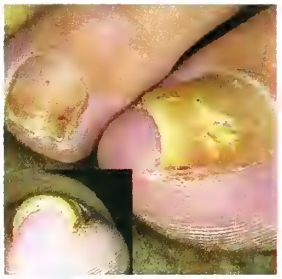
Staphylococcus aureus, *Candida albicans* and *Pseudomonas* species. Involvement of the matrix leads to characteristic transverse ridges of the nail plate. The condition is more common in people whose hands are continually wet, and those with poor peripheral circulation as in perniosis (chilblains). Treatment usually requires GP referral and a course of oral antibiotics. Less severe cases may respond to topical antibiotics, and advice to keep the hands as dry as possible.

Pincer nails

The nails, also known as trumpet nails, have an exaggerated transverse over-curvature. It may be hereditary, in which case the fingernails may be involved, but usually only the toenails are affected. The main complaint is of pain, caused by the lateral edges of the nails turning under and piercing the skin, as occurs with in-growing toenails. Treatment is not always required but if so, the only successful way of relieving the pain is to excise the lateral edge of the nail on both sides. This can usually be done by a podiatrist.

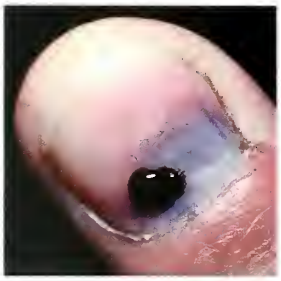


Recurrence is common, as the nails tend to grow back in the same shape. If repeated treatment is required then a further option would be removal of the whole nail with ablation of the nail bed, preventing the nail from growing back. This is required only rarely and needs careful consideration, as it is a permanent procedure.

Subungual haematoma

When there is trauma directly on to a nail, it is quite common for bleeding to occur between the nail and the nail bed. This gives an instant black appearance and, because of the restricted space, the pressure from the bleeding can cause a lot of pain.

The easiest way to relieve the pain is to reduce the pressure under the nail by burning a hole in the nail directly over the blood using a cautery machine or sterile needle. It is usually a painless procedure and produces instant relief. The residual blood then takes many months to grow out.



Discoloured areas that do not appear to be growing out should be treated with suspicion, especially if the patient cannot recall a bruise, as it may be a subungual malignant melanoma requiring an urgent hospital appointment for a biopsy.

Resources

- British Association of Dermatologists' guidelines for treatment of onychomycosis: www.bad.org.uk/healthcare/guidelines/Onychomycosis.pdf
- Emedicine Nail Pathology Article: www.emedicine.com/orthoped/topic421.htm

Dr Nigel A Stollery is a GP at Kibworth Health Centre, Leicestershire, and clinical assistant in dermatology, Leicester Royal Infirmary. Pictures supplied by Dr Stollery.

Continuing Professional Development CPD

Act

- Using the article, make a note of nail markings that should be referred to a GP.
- Revise the actions and uses of amorolfine in treating fungal nail infections. Make sure you know which infections may be treated topically (and what they look like) and which should be referred. A previous Pharmacy Update article (C+D, May 13, 2006, p21-23) gives information on symptoms, causes, prevention and treatment of fungal nail infections.
- Revise the oral use of terbinafine, particularly the side effects.
- Read the reference mentioned in the article – www.emedicine.com/orthoped/topic421.htm – and the clinical knowledge summaries on fungal infections in skin and nails at www.cks.library.nhs.uk
- What do you recommend for persistent nail biters? An NHS patient leaflet on "What can I do about my bad habits?" gives brief advice on nail biting and toe picking – http://tinyurl.com/yvmyh3

Evaluate

- Do you now know enough about the various nail conditions patients may present in the pharmacy? Are you able to give good advice on any treatments you supply, both prescription and OTC?

For a free weekly email alert on C+D's Pharmacy Update series, please register at:

www.chemistanddruggist.co.uk/register

C+D Clinical bulletin

Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the March 1 issue, which will cover this month's three CPP-accredited modules. A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on **01732 377269**.

Chemist+Druggist in association with Genus Pharmaceuticals

C+D GENUS PHARMACEUTICALS

Registration of overseas pharmacists

Bethany Straker

Julia O'Reilly, pre-registration trainee at Update pharmacy, has returned to her home in Ireland, for a few days vacation. There, she meets up with her old school friend Grainne, also a trainee pharmacist. They are talking about their future plans.

"Cork's a nice place, but I've lived here all my life and I'd like to see a bit more of the world once I'm qualified," says Grainne. "I'd like to live and work in London. That's no problem for you Julia, because you trained in England. But I studied and trained here, so I wonder if it would be so straightforward for me? It's not just me, either. I've kept in touch with some of the guys we met at that international pharmacy students' conference, and Enrique tells me that he's thinking of moving to England. And do you remember Vijay from India? He's got family in Manchester, so is thinking of trying to find work there. But I expect they'd both at least need to prove that they can communicate in English."

"I'm not sure," Julia replies. "And I wonder if I'd be able to work here in Ireland some day?"

Questions

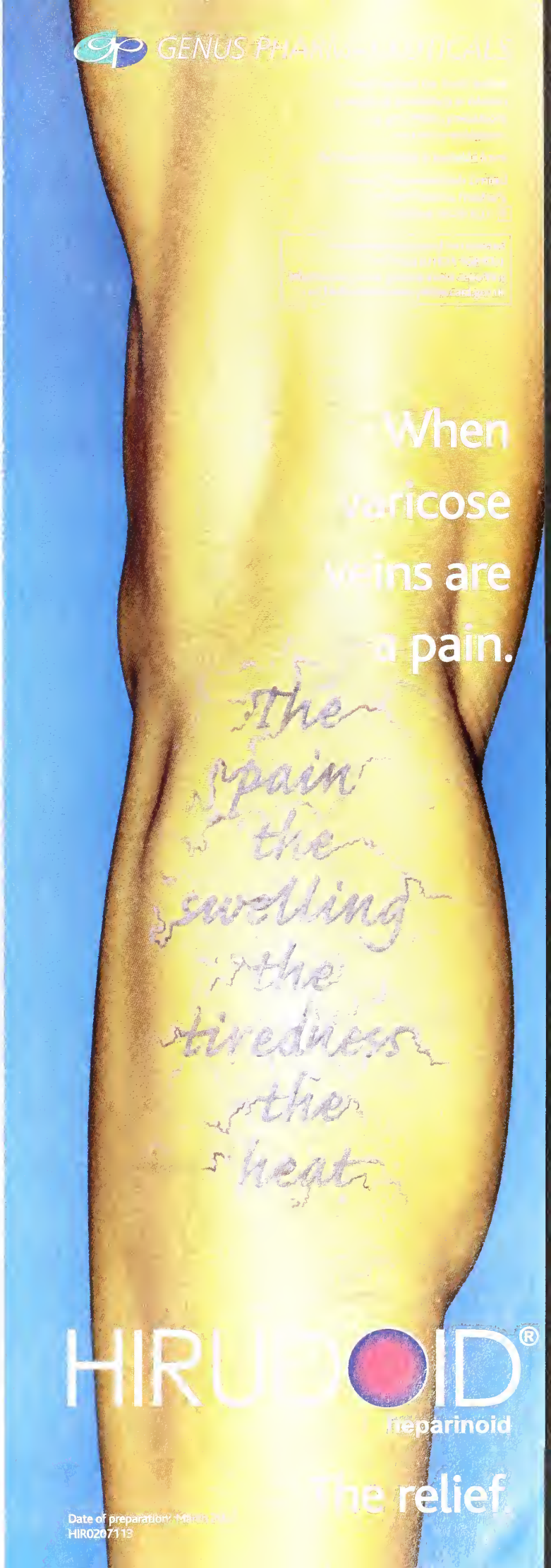
1. What are the requirements for Grainne to practise as a pharmacist in the UK, and for Julia to practise in Ireland?
2. What would the requirements be for Enrique? And Vijay?

Answers

1. The requirements for Grainne and Julia would be exactly the same, as the UK and Ireland are members of the European Union and EU regulations allow free movement of pharmacists between member states. Grainne and Julia would just need to supply to the registering body in the country in which they wish to work the following:
   - proof that they are registered as pharmacists
   - a certificate of 'good standing' from their national registering body (currently the RPSGB for pharmacists in Great Britain), ie that they have not been the subject of any disciplinary proceedings and have none pending.
2. For all pharmacists from countries outside the EU, except Australia and New Zealand for which there are separate and slightly less stringent arrangements, the requirements are:
   - proof of proficiency in English (passing the International English Testing System [IELTS] test at a prescribed level)
   - proof of a pharmacy degree or diploma, of at least three years' duration and equivalent in standard to a UK bachelors degree
   - proof that the pharmacist is registered and in good standing in their own country.

Applicants then have to undertake and pass a one-year overseas pharmacist's course at a UK school of pharmacy, followed by the same one-year pre-registration training programme and examination as undertaken by pharmacy graduates in Great Britain.

CPD This article can help in the following CPD competencies: **G1g, G1h, G3g.** See www.tinyurl.com/194zu



Sign up for clinical news and CPD articles by email at:
www.chemistanddruggist.co.uk/register

Clinical Alerts

New Products

Episenta ampoules 1,000mg/10ml (sodium valproate) New strength.

SPC Changes

Elleste range (norethisterone, estradiol) Transferred from Pfizer to Meda.
Dilzem range (diltiazem) Gingival hypertrophy, thrombocytopenia and gynaecomastia added to side effects. New warnings on use with simvastatin, atorvastatin, amiodarone and enzyme inducers such as rifampicin and phenobarbital.
Minodiab tablets (glipizide) Warning on possible interaction with voriconazole.
Tygacil injection (tigecycline) Warning on the need for monitoring for the onset or worsening of acute pancreatitis.
Vascace tablets (cilazapril) Blood disorders added to side effects.
Reyataz capsules (atazanavir) Updated contraindications, warnings and interactions sections.
Nizoral 200mg tablets (ketoconazole) Amended indications, duration of treatment and warnings on hepatotoxicity.
www.emc.medicines.org.uk

Supply problems

MigraMax sachets 20s (lysine acetylsalicylate, metoclopramide) Currently unavailable.
Cephalon, tel: 0800 783 4869.

Drug Tariff listings

Tubifast gloves, small child size
Mölnlycke, tel: 0800 7311 876.
Flexitol Heel Balm
M&A Pharmachem, tel: 01942 816184.

Discontinued Products

Nystan vaginal cream 60g (nystatin) Discontinued with immediate effect for commercial reasons.
Duphaston range (dydrogesterone) Discontinued from March for commercial reasons. Solvay, tel: 023 8046 7000.

Nice counsels caution on drug use in ADHD

Medication should not be offered as first-line treatment for attention deficit hyperactivity disorder (ADHD) unless symptoms are severe, Nice is proposing.

In draft guidance on managing ADHD, Nice states that drug treatment should always form part of a comprehensive treatment plan that includes behavioural and educational interventions. If medication is deemed appropriate, methylphenidate should be tried first, both for children and adults.

If accepted, the Nice recommendations would see group parent-training programmes, and individual or group therapy, tried first for school-age children with moderate ADHD. Drug treatment would be offered for persistent cases.

Atomoxetine would be used for patients who were intolerant or unresponsive to methylphenidate, with dexamfetamine reserved for resistant cases. Nice promotes the use of modified-release methylphenidate to improve compliance and reduce stigma, but states that antipsychotics should not be used.

The consultation runs until the end of March, with Nice expected to publish its guidance in August.
http://tinyurl.com/2v6wem

Keep antibiotics special, says DH

"Antibiotics do not cure all ills" is the message of the Department of Health's newly launched public education campaign.

The initiative aims to remind patients and prescribers of the dangers of antibiotic resistance, and the need to preserve drugs for those who really need them. Campaign material will be displayed in pharmacies and GP surgeries, as well as in national newspapers and magazines, and is available at www.nhs.uk/antibiotics

Water said to be as good as saline

Tap water may be used to clean wounds instead of saline, a Cochrane review has suggested.

The analysis considered 11 trials comparing water with other wound cleansers or no cleaning at all. Using drinking water did not seem to increase the incidence of infection for chronic or acute wounds in adults, acute wounds in children, or open fractures.

The authors conclude: "There is no evidence that using tap water to cleanse acute wounds in adults increases infection and some evidence that it reduces it." However, they stress that there is a lack of evidence supporting the practice of cleansing wounds to increase healing or reduce infection.

FDA issues anti-epileptics warning

The US drug regulator has warned that patients taking anti-epileptics may be at increased risk of suicidal thoughts and behaviour.

The Food and Drug Administration (FDA) issued the notice following analysis of placebo-controlled studies of 11 epilepsy drugs, involving nearly 45,000 patients. This work found that patients taking these drugs appeared to be twice as likely to contemplate suicide as those on placebo, though the figures for both groups were small (0.43 and 0.22 per cent respectively).

The raised suicide risk was observed as early as one week after starting treatment, and continued to at least 24 weeks. The results were generally consistent across all the drugs studies – which included topiramate, valproate, gabapentin, carbamazepine and lamotrigine – and there was no clear pattern of risk across age groups.

Patients on anti-epileptics for any condition should not stop or change their medication, the FDA warned. However, health professionals should notify patients and their carers of the potential risk.
http://tinyurl.com/36jmqv

Clinical News

New hope for UI sufferers

Topical oxybutynin looks like being the next big thing for urinary incontinence sufferers. Two companies are said to be developing oxybutynin gel products, in the hope of delivering the benefits of tablet formulations with fewer anticholinergic side effects. Analyst Datamonitor says phase 3 trial results look promising.

No aspirin benefit in some

Patients with diabetes may not benefit from aspirin after acute coronary syndrome. A study in Diabetes Care found that while non-diabetics derived a 48 per cent reduction in mortality from aspirin, there was no significant benefit for patients with diabetes.
http://tinyurl.com/2soo9k

Short antibiotics courses are effective in COPD

Short courses of antibiotics may be as effective as traditional longer courses in patients with mild to moderate exacerbations of chronic bronchitis and COPD, a meta-analysis has revealed.

The researchers examined 21 studies including a total of 10,698 subjects with mild to moderate exacerbations of chronic bronchitis and COPD who took either short courses under five days, or long courses over five days.

The results revealed a summary odds ratio for clinical cure with short treatment versus long of 0.99 at early follow-up. At late follow-up and on bacterial testing the odds ratios were 1.0 and 1.05 respectively.

British Lung Foundation honorary medical director Dr Noemi Eiser said that it was difficult to draw firm conclusions from the meta-analysis because the included studies were not directly comparable.

However, she said using shorter antibiotics courses could help prevent patients from acquiring other infections, such as C difficile.

http://tinyurl.com/2776lw

More people pledge to stop smoking

The numbers of people setting a quit date rose by 29 per cent to 327,800 last year, according to government figures.

During the year, new legislation banned smoking in enclosed public places and the stop-smoking treatment varenicline (Champix) was launched.

Varenicline proved to be the most successful smoking cessation aid, according to statistics from the NHS Stop Smoking Services in England report (April to September 2007). Some 10 per cent of quitters were given the treatment, and of these 64 per cent quit successfully.

• The FDA has warned patients and carers to be alert for severe changes in mood and behaviour in those taking varenicline.

http://tinyurl.com/2pkjer

Clinical News

Omeprazole side effect

Omeprazole may significantly reduce clopidogrel's ability to inhibit clotting, the authors of a paper published by the Journal of the American College of Cardiology have reported.

http://tinyurl.com/34nkj6

RA treatments and infection

Rituximab and abatacept treatments for rheumatoid arthritis are not associated with increased risk of serious infections, the authors of a major meta-analysis have reported. However, high dose anakinra treatment may increase risk in some patients.

http://tinyurl.com/2l4uoq

No evidence for probiotics

Cochrane reviewers conclude that there is insufficient evidence to recommend probiotic therapy as an adjunct to antibiotics in treating C difficile colitis.

http://tinyurl.com/2cb2yf

Pancreatin PIL of the month

Pancreatin is the subject of the MHRA's latest PIL of the Month. The series is an initiative to promote examples of best practice in preparing PILs.

http://tinyurl.com/ypol4x

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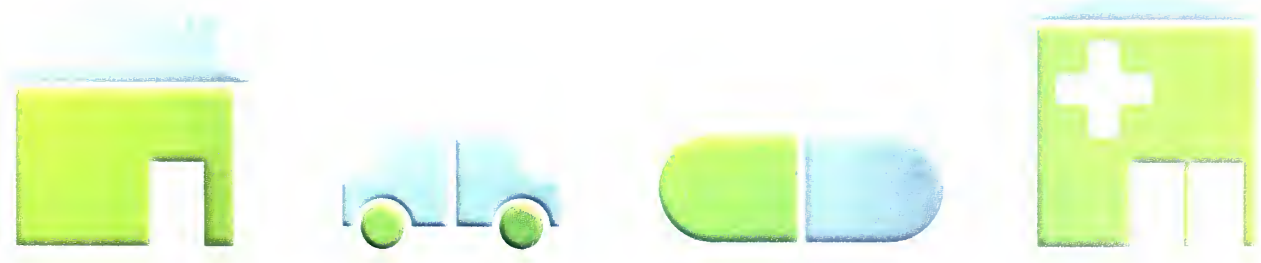

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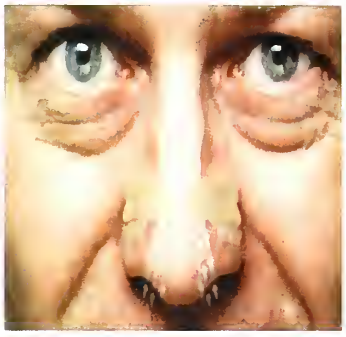
Why seeing is believing

Breathe Right nasal strips begins a £750,000 national television advertising campaign this week.

Running until March 10, appearances will favour pre-bedtime and early morning slots when sleep disruption is most in consumers' thoughts.

The 'Believe' ad has been updated to give clearer messages about the product's benefits, says GSK. Viewers see a couple getting ready for bed while a voiceover explains how the strips open the nasal passages and aid breathing. The ad closes with the new strapline: 'Breathe better. Sleep better. Feel better. Breathe Right.'

Product info:
GlaxoSmithKline
Tel: 0845 762 6637



Simple targets dry skin

Skincare brand Simple is branching out into dry skin treatment with the launch of a Derma range. The cream and lotion products claim to give results in four days. Also available are hand cream and non-foaming shower cream formats.

As well as dry and sensitive skin sufferers, the products are suitable for those prone to eczema and dermatitis, says manufacturer Accantia. The products are hypoallergenic, dermatologist approved and suitable for children.

Marketing activity supporting the launch includes online, sampling and in-store activity. Samples can be requested from the range's website, www.simplederma.co.uk

Prices and pip codes:
see C+D Price List
Accantia Health & Beauty
Tel: 0121 712 6583

Heel balm now on prescription

Flexitol Heel Balm has been reclassified as a medical device by the NHS BSA pricing prescription division.

As a result, two new packs have been introduced for dispensing against NHS prescriptions.

The existing retail packs (S6g and 112g) are not eligible for reimbursement.

DT prices and pip codes:
£4.35/75g, 334-1989;
£9.90/200g, 334-1997
M&A Pharmachem
Tel: 01942 816184
info@mapharmachem.co.uk

Time to spruce up the bladder

AOR D-Mannose as been launched in the UK by Canadian manufacturer Advanced Orthomolecular Research.

Derived from the spruce tree, the sugar in the product is said to support the health of the urinary tract. It flushes out harmful bacteria in the urine and strengthens natural defences, claims the company. Three tablets should be taken daily.

PR activity in the national media supports the launch targeting women aged 18 to 55 years.

Price: £12.99/30
Advanced Orthomolecular Research
Tel: 0800 169 1231

Gloves for kids

A smaller size of the Tubifast Gloves, designed for small children, has been launched by Mölnlycke Health Care, bringing the range to five sizes. The gloves are available on the Drug Tariff to sufferers of hand eczema. They cover the hand and wrist, ending midway to the elbow, and are seamless for comfort. The manufacturer suggests using them in conjunction with Epaderm emollient.

Product info:
Mölnlycke Health Care
Tel: 0800 917 4918
www.skincareworld.co.uk

Products in brief

Droyt's organic launch

Organic soap is newly available from Droyt. Containing vegetable oils, vegetable-derived glycerine and essential oils for fragrance, the transparent soaps are approved as 95 per cent organic by the Soil Association. Liquid and bar formats are available and an organic gift range is expected to launch soon.
Prices: liquid £5/250ml; bar £2
Droyt, tel: 01257 417251
www.droyt.com

Dozol moves on

Sales and distribution responsibilities for Dozol (paracetamol/diphenhydramine) have been taken over by M&A Pharmachem. Tel: 01942 816184.

New fibre provider

The gluten-free pasta range from Juvela has been extended to seven lines with the launch of two fibre variants. Fibre Penne and Fibre Linguine are both available on prescription to patients with coeliac disease or dermatitis herpetiformis, or can be bought OTC.

Claire Monks, marketing manager, commented: "Getting enough fibre into the gluten-free diet has often been a challenge for coeliacs. Our fibre pastas contain 7g of fibre per 100g, making them a high fibre choice."

Price: £5.69/500g
Pip codes: linguine 332-8002; penne 332-8010
Juvela
Tel: 0151 432 5350

Products advertised on TV next week

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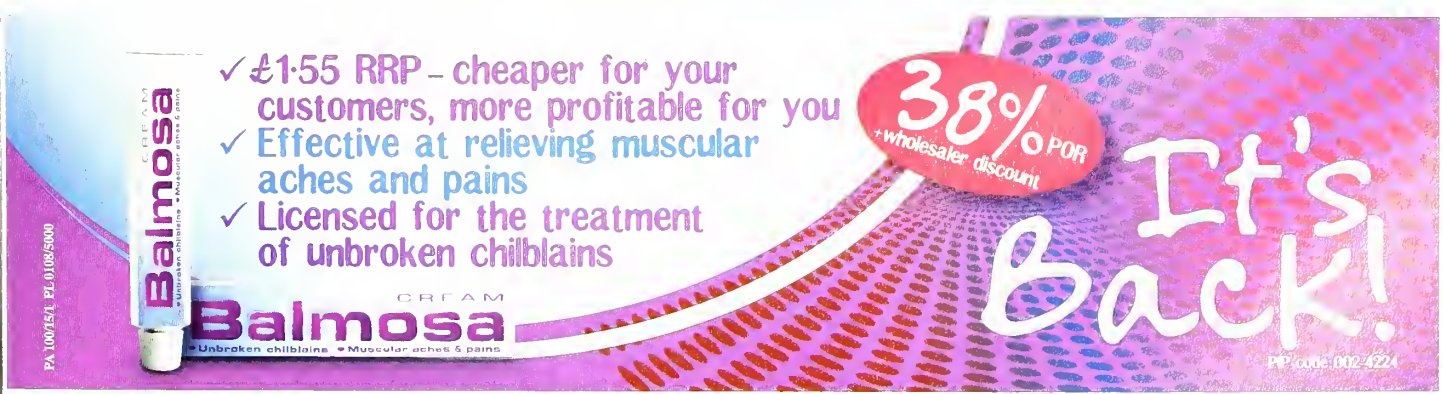
Abidec: five
Beechams: All areas, except GMTV
Buscopan: GMTV
Buttercup Cough Syrup: All areas except five
Covonia: GMTV, Sat, five
Cura-Heat: All areas, except GMTV
DulcoEase: GMTV, Sat, five, LWT, CAR
Lanacane: All areas
Olbas Powerflu: GMTV, Sat
Seven Seas JointCare & CLO: All areas
Vagisil Wash: All areas
Voltarol: All areas
WindSetlers & Setlers Heartburn: GMTV, five
PharmaSite for next week: Meltus – windows, **Meltus** – in-store, **Meltus** – dispensary
Pharmacy channel: NiQuitin, Fusion Condoms, Clearly Baby Wipes

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire



Balmosa is a warming pain relieving cream that soothes and relieves the pain of unbroken chilblains and muscular aches and pains. It can also be used to relieve the symptoms associated with frostnip, stinging, burning, back pain and sciatica. **Directions for use:** Adults and children over 12: Apply Balmosa cream onto the affected area and gently massage onto the skin. Use Balmosa cream as frequently as required. If accidentally swallowed seek medical advice. **Caution:** Do not apply to inflamed or unbroken skin or near the eyes, nostrils or other sensitive areas. If you are pregnant, breastfeeding or are sensitive/allergic to aspirin or any of the medicine listed contact your pharmacist before use. Keep out of the reach and sight of children. For external use only. Do not use after expiry date shown. Do not store above 25°C. Active ingredients: camphor 4% w/w menthol 1% w/w, and capsicum oleoresin 0.035% w/w. Marketing Authorisation Holder: Forest Labs UK Ltd, Bexley, DA5 1NX, UK. **Legal Category:** GSL. Prescribing information last revised: April 2003.

Jeremy Poole has been burning the midnight oil reading the OFT report into direct to pharmacy distribution. Was it worth the sleepless nights?

Is there life after OFT?

Last spring I looked at the strategic issues facing UK wholesalers and their customers precipitated by the Pfizer scheme (C+D, May 5, 2007, p36). Ten months on, the OFT has published its Market Study into Medicines Distribution; more companies have or will take related action so that with the GSK scheme at least a third of primary care prescription value is distributed via some form of DTP. Have things changed?

Commendably, the OFT study was broadly on time, with a clear, comprehensive analysis of the issues. Anyone with an interest in the medicines supply chain should read at least the executive summary. In essence, the study recognises a potential for 'changes' in service levels and future intervention into wholesale market power, but concludes that manufacturers should be free to choose the distribution method they consider to be most efficient.

Within this is the key proviso that DTP should not be used to circumvent PPRS arrangements and increase cost to the NHS. Explicit recommendations are made to the Department to pre-empt this eventuality through protecting the quantum of pharmacy ethical discount in the short run and at the aggregate level. Here endeth the good news for pharmacy, and citizens (as taxpayers and patients).

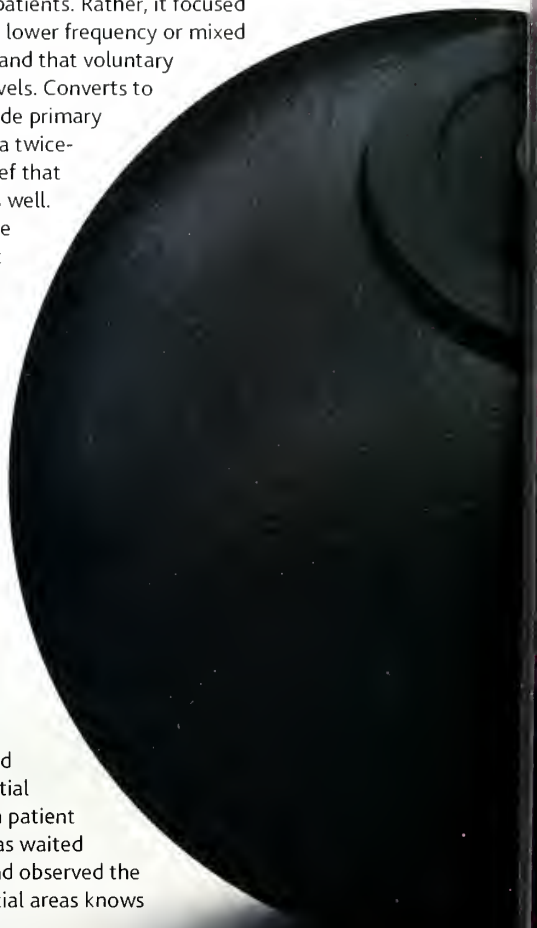
Ostensibly 'laissez faire', the study might more pragmatically be regarded as a holding position pending the outcome of the PPRS, a negotiation surely now with increased stakeholder interest beyond the Department and ABPI. It is this emphasis on the branded medicines of PPRS members that limits the study as a comprehensive review of medicines distribution and generates a number of consequences:

- The study reiterates rather than challenges the status quo of the inefficient and fractured system by which the NHS procures its medicines and related services. Opportunities for re-engineering to improve service and reduce costs may be missed.
- The use of prescription value (limited dispensing choice) as a proxy for NHS cost rather than prescription volume (wider dispensing choice) as a proxy for patient-focused activity has the potential to distort policy making and resource allocation to the detriment of the patient experience.
- A decision not to intervene, even in the short term, will exaggerate the pre-existing competitive supply chain dynamics. In short, the gap between major vertically integrated groups, smaller full-line wholesalers and independent pharmacies will grow faster than pre-DTP adoption.

To support these statements it is necessary to look in a little more depth at some of the study findings in the context of the broader community pharmacy environment.

Will the twice-daily service survive?

The OFT sees a risk of increased patient waiting times, but did not attempt to determine if twice-daily is the most efficient or optimal way of getting drugs to patients. Rather, it focused on ensuring that any savings from a lower frequency or mixed two-tier service accrue to the NHS and that voluntary agreements be sought on service levels. Converts to DTP with product ranges seeking wide primary care usage have thus far supported a twice-daily service, strengthening the belief that this serves the NHS and its patients well. Seemingly neither politicians nor the branded industry are keen to be left with the smoking gun. More importantly, basing future decisions primarily on a twice-daily service for branded ethicals in isolation risks real patient service deterioration.



Current wholesale deliveries are healthcare dedicated, tightly scheduled, reliable and predictable over time. In addition to branded ethicals they carry pretty much anything required by a pharmacy, its customers and patients. Loads, routes, receipts, stock etc are all pretty well optimised. An increase in other models, eg next day, would significantly increase the volume and unpredictability of receipts, a potential inefficiency recognised by OFT, with patient service implications. Anyone who has waited for a four-hour 'delivery window' and observed the number of carriers entering residential areas knows the answer.

True, it has been in the wholesalers' interests to preserve what some suggest is 'over service' but coupling this with maintaining comprehensive stocks within minutes rather than hours of population centres not only constitutes a barrier to entry but underwrites all other models including suppliers' freedom to choose. Hence even allowing for the fact that customers might elect to take am and pm from different parties, it is unlikely that twice-daily to third party customers will be an early casualty of the squeeze put on wholesaler revenue by DTP. There are other potential candidates from the raft of services they currently provide. Some are explored below and stakeholders might wish to consider the wider repercussions.

	TRADITIONAL MODEL	POST-STUDY DTP MODEL
PPRS manufacturer	• Passes 12.5 per cent distribution margin to all full-line wholesalers, prima facie subsidising distribution of competitive products and services from which it derives little benefit	• Controls both components of distribution margin • May or may not realise efficiency savings [illegible] paid as an LSP fee to fewer wholesalers • Free to set own pharmacy discount [illegible] a significant proportion of pharmacy discount [illegible] but anomalies in the system still allow [illegible]
Wholesaler	• 12.5 per cent represents a major revenue stream which it applies to the profitable growth of its own business • Competitive forces dictate that 10.5 per cent is passed on to pharmacy customers, leaving 2 per cent to run the business at a profit. Flexibility in both components enables the traditional twice daily model and a range of added value ancillary services	• Successful DTP contractors suffer turnover loss but impact mitigated by volume gains, together with reductions in financial risk and working capital • Reduction in discretionary support for customers
Community pharmacy	• Branded/ethical discount after clawback is a major source of revenue and together with wholesaler added value services is used to build business and patient loyalty	• Purchase profits protected in short-run but will eventually impacted by volume discounts • Reduction of mission critical support services from wholesaler
Department of Health	• Claws back 9 per cent and 'underwrites' the ethical component of retained margin in pharmacy contract	• Needs to maintain status quo to honour current pharmacy contract

'Ethical discount' – a question of control

The provenance and longer term future of the PPRS 'distribution margin' has always been at the core of DTP initiatives. With the custom and practice 12.5 per cent representing around £625 million, its control and allocation is hard fought over. The table above gives a simplified summary of how the change in overall control from wholesalers to DTP manufacturers redistributes the sum. Some impacts are discussed below and result from changes in both the value and greater constraints on its use of these flows.

Unfettered DTP and manufacturer specific discount schemes accentuate the growing gap between large and small. The commercial logic of fishing with the big fish, particularly when brand equalisation is taken into account, is irrefutable. Resistance to rewarding collective loyalty is less obvious and may change since the study draws attention to the potential for anomalies created by the discount inquiry independent pharmacy bias.

Ancillary services or where wholesale adds value

Information technology: it can be argued that in relative terms EPS has been the most successful pillar of CfH and that wholesalers have been instrumental in pushing it. Will they still have the resource and motivation to continue the provision and development of PMS systems, let alone lobby for wider pharmacy access to NHS systems?

Financial support: under the current climate, initial and continuing funding for pharmacy will be difficult. It might be argued that pharmacy insolvencies are inevitable, even desirable. Wholesalers will be increasingly reluctant to act as guarantor or extend terms.

Pharmaceutical care: The D'Arcy Angle (C+D, January 19, p16) neatly summarises the position of pharmacy within healthcare provision, yet the OFT study recognises there is a danger in DTP leading to a reduction in the time pharmacists spend with patients. In the event that wholesalers stop investing and supporting their customers in this area, it represents a double whammy for patient care.

The study alludes to the fact that the pharma industry could fill the gap, using the closer relationships and transparency DTP brings to target improved support for products and services. However, there is potential for conflict of interest.

For instance, how would the balance between individual product usage information and the patient's wider medicines management needs be maintained? A possibility, which would be relevant if pharmacist prescribing becomes widespread, would be to reposition the discount as a levy on sales, which, after reasonable costs for physical distribution, is transparently ploughed back into patient focused pharmaceutical care. Given some flexibility, pharma companies would be investing through community pharmacy in proportion to their market share and therapeutic interest. This would be empathetic with other PPRS allowances and the direction of the pharmacy contract.

> "ETP will come and e-solutions will increasingly underpin patient services such as MURs and MAS"

The AAH view

"The one size-fits-all traditional wholesale model has gone. At AAH, our commitment is to provide suppliers with bespoke innovative solutions which meet their particular individual needs: for some that will be a wholesale model and for others agency agreements.

"What differentiates AAH is our partnership approach which allows suppliers to maximise their relationship with us, but which also helps them establish stronger and mutually beneficial relationships with dispensing customers.

"Through LINK, AAH will remain a key supplier of IT solutions to our customers. Despite the delays there can be little doubt about the direction of travel. ETP will come and e-solutions will increasingly underpin patient services such as MURs and MAS.

"Finally, we will no doubt see further scrutiny of health budgets, including the cost of drugs. The reality is that all aspects of the supply chain are inextricably linked: if you take money out of one aspect it impacts upon the others. If suppliers or dispensers are squeezed then wholesalers/agents feel the impact of that as well."

Mark James, group managing director, AAH Pharmaceuticals

DTP – direct to pharmacy or direct to patient?

Earlier it was suggested potential weaknesses of the study were augmentation of existing market power and failure to address the arcane and partisan system by which the NHS procures drugs and services. Additionally, there is a feeling that pharmacy is reactionary and not moving quickly enough to embrace change – might this mixture ferment radical solutions?

Automated, centralised dispensing operations sometimes referred to as 'hub and spoke', have been under development for years and the advent of EPS will accelerate this. In parallel, models for the home delivery of drugs and care packages have matured.

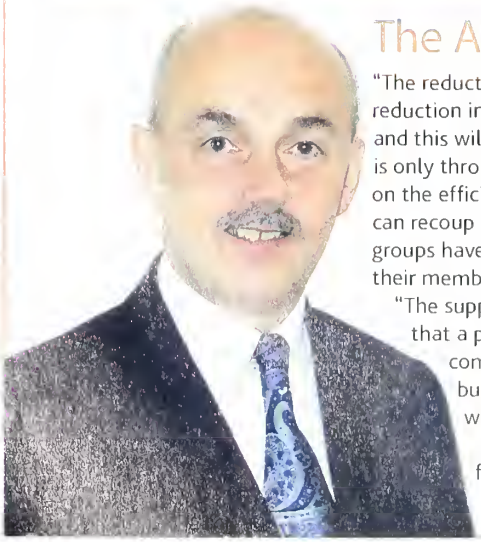
A scenario where the bulk of repeat prescriptions were reviewed and dispensed centrally by firms taking responsibility for product movement, transactions and pharmaceutical care would considerably reduce workload in surgeries and pharmacies.

Effectively these firms would be delivering dispensed prescriptions rather than stock; either direct to patients or via franchised pharmacies. Title would remain with the centralised dispenser, thus minimising transactions with pharma suppliers and the PPD while giving greater transparency of ingredient and professional costs. The benefits are seductive.

Implications for wholesalers and customers

Should the OFT recommendation not to intervene in the manner of distribution for branded ethicals be accepted, it serves mainly to accelerate existing competitive trends. Although their individual positions vary and UniChem has stolen a march by achieving accounts with all UK pharmacies, life goes on much as before for the three vertically integrated market leaders.

Turnover has taken a hit but impact on profit is mitigated by volume and cash flow gains. Ironically a move to activity based fees may provide some insulation against the PPRS price reductions the government is flagging (FT, January 7, 2008). Even if the OFT volume shares of circa 90 per cent for wholesale and 40 per cent for related retail NHS revenue is overstated it tells its own story. There will be need for organisational adjustments to manage the changing relationship with branded pharma and it will be interesting to see how each revises its third party customer offer to the different segments.



The AlbaPharm view

"The reduction in category M pricing has seen a huge reduction in profitability for community pharmacies and this will really begin to bite in the year ahead. It is only through developing new services and focusing on the efficiency of their businesses that pharmacists can recoup some of this loss. It is here that symbol groups have an important role to play in supporting their members to maximise their income.

"The support of a buying group is the only way that a pharmacist can obtain discounts comparable to what the multiples achieve but they also allow pharmacists to focus on what is really important.

"There is much talk of doom and gloom for independent community pharmacies in the face of the increasingly dominant share of the market held by the multiples. However, in all periods of change there are opportunities and independents have strengths and a unique role to play which the multiples may find hard to replicate.

"The independent knows and understands their customers and they offer flexibility and the highest service standards. Through support, as well as discounts, symbol groups can assist the independents to maximise their business and with a broad membership base they can meet the challenge from the multiples.

"The survival of a strong independent community pharmacy sector is in the best interests of patients and by working together independent community pharmacists and symbol groups can deliver a viable future."

David Currie, chief executive, AlbaPharm Ltd

The Numark view

"The argument for being a member of a symbol group has become stronger with the advent of the new contract and in increasingly competitive times. Independents have suffered disproportionately with some of the recent changes to pharmacy and the pressures on those who don't belong to a group must be immense. By joining commercial deals, such as those provided to Numark members, independents can help maximise their margin without the need to self-source – which can be a time-consuming task. Being a member of a group can help independents minimise the impact of ongoing margin erosion with purchasing schemes and additional support from suppliers. Access to professional marketing support, IT assistance, a quality own-brand offering and training programmes for the pharmacist and their team are all powerful reasons to become a member of a group like Numark.

"Independents are potentially threatened now more than at any other time but they have the tools and ability to really provide what their community wants. Pharmacists need to let go of the tasks that don't need the pharmacist's input and get in front of the customers – this can be an essential point of difference from the multiples and grocers who don't provide a consistent point of contact. Not weighed down by large corporate mentality they can decide to change – and implement it quickly. Healthcare is becoming much more localised – so play to your strengths, clean up your stores, engage with your staff and customers and you will really make a difference to your local community!"

John D'Arcy, interim managing director, Numark

With legislative protection unlikely, the financial impact on smaller regional full-line players is major. To their credit they continue to adapt by forming alliances and exploring niches in substitute products, patient services and other customer groups. Limited DTP exposure may offer greater freedom within the Drug Tariff element of purchase profit.

For the majority of retail customers, the choice of 'numero uno' wholesaler is unchanged. The administrative burden also needs to be kept in perspective; most have always had at least a number two and several lower frequency shortline or direct accounts. Critically what does change is:

1. the increased and continuing necessity to have an account with at least one major vertically integrated wholesaler.
2. how each of the major wholesalers repositions its offer to third party customers in the light of changes to its revenue stream.

The announcement surrounding the Phoenix acquisition of Nucare recognises the new reality, with expectation of benefits from international operations, symbol group leverage and the maintenance of trading relationships with AAH and UniChem. More generally, customers should keep their choice of wholesalers under active review, remembering that headline 'ethical discount' needs to be increasingly balanced by ethos, wider support packages and the competitive supply of 'non-ethical' product groups. Consider rebalancing purchase volumes so the number one slot becomes less of a given over time. Ensure that support packages and deliveries are tailored to your business by developing objective criteria.

Owner-managers are the experts in positioning their business locally but will need to be even more realistic in terms of value and viability. There is strength in numbers. Selectively join alliances, ensure maximum benefit from symbol groups and virtual chains. Lobby trade bodies mercilessly but encourage emergence of a dedicated voice for independent pharmacy. Historically, UniChem members and others have demonstrated that mutuality aids survival and can lead to healthy returns.

Jeremy Poole is an independent consultant with extensive experience in wholesaling
jfpoole@msn.com

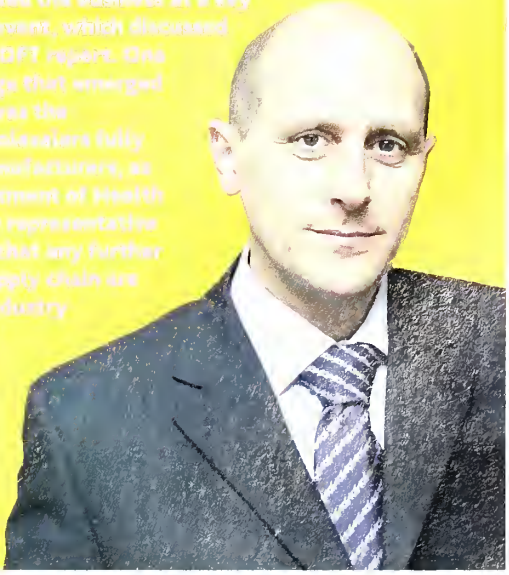
The UniChem view

"In 2007 we witnessed one of the biggest changes to pharmaceutical wholesaling in 40 years, with the implementation of Pfizer's direct to pharmacy agreement. Other suppliers have since reviewed their supply arrangements and implemented changes. Following the publication of the OFT's report on medicines distribution, I expect that we are likely to see yet more changes to the traditional wholesaling model, which will have further implications for existing UK wholesalers, as well as the wider supply chain.

"The effects may be financial, with possible reviews of PPRS and the clawback mechanism, and will most likely result in a completely new way of operating for wholesale in the years to come. Other ongoing challenges such as rising operational and fuel costs mean that wholesale will continue to operate in a tough marketplace, and it is important that the sector makes its voice heard on these issues.

"At UniChem we continue to focus on pioneering a co-operative way of thinking that brings benefits for wholesale, the pharmacy profession, and the pharmaceutical industry as a whole. Mark Stephenson, UniChem's supplier relations director, recently represented the business at a key pharma industry event, which discussed findings from the OFT report. One consistent message that emerged from the debate was the importance of wholesalers fully engaging with manufacturers, as well as the Department of Health and the pharmacy representative bodies, to ensure that any further changes to the supply chain are beneficial to all industry stakeholders and ultimately, of course, the patient."

Terry Sekcuna, managing director, UniChem



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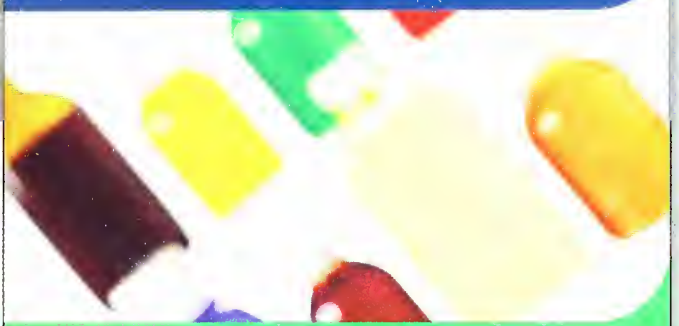

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From: **Hawkeye on the web**

Date: Sat 9.2.08

Subject: Size matters

Proportionally speaking we're no more overweight than we were in 1993

A lot can change in 15 years. Back in 1993, Europe became a single market, Bill Clinton became the 42nd president of the USA and the Railways Bill signalled the beginning of the privatisation of British Rail.

The world has moved on a long way since then but figures published on the NHS Information Centre website this week revealed there is one thing that hasn't changed: the level of the English population who are classified as overweight (www.tinyurl.com/2rbvaq).

Yes, proportionally speaking, we're no more overweight than we were in 1993. What we are, however, is far more obese. Almost a quarter of the population now sit in the obesity band and by 2050 it could even rise to 60 per cent (www.dh.gov.uk).

Going behind the headlines, things aren't all bad. Since 2005 the number of people consuming five or more a day has increased significantly and the average proportion of people achieving the recommended levels of physical activity has jumped from just over a quarter to more than a third.

But using The Information Centre's measurements for BMI and waist circumference to assess health, more than half of men and women are in the 'at risk' bracket.

This rise in obesity levels, along with the introduction of sibutramine and orlistat in the interim, has seen prescriptions for weight-reduction drugs soar to one million a year (www.tinyurl.com/27gbgn).

While GPs say this headline figure should be considered in the context of the 676 million consultations now made every year, others argue that doctors are turning to the prescription pad because they don't have the time to provide diet and exercise advice.

For pharmacy, this underlines the opportunity to deliver weight management services using the funding promised in the government's Healthy Weight, Healthy Lives strategy (www.foresight.gov.uk).

What do you think?
Email thawkins@cmpmedica.com

... your views on the C+D website ...

PSNC: Lansley wrong over £811m overpay

Posted by Sam Morein, on 03/02/2008 11:24

"By trying to hide the excess payments from the DH the PSNC has made contractors look greedy and unscrupulous. PSNC and the DH should publish the method used to determine purchase profit levels so that contractors can feel confident that a suitable method is being applie"

MPs shun pharmacies

Posted by Sachin Badiani, on 31/01/2008 20:37

"DH spokesperson: "Ministerial visits are not the only way to assess the views of the pharmacy profession."
Sachin to DH: "Care to mention the other ways to assess the views of the pharmacy profession? Or is it more questionnaires pharmacy contractors need to fill out to give their views???" Good luck C+D with your campaign. I'll be lobbying my local MP soo"

Push for national minor ailments programme

Posted by Mukesh Lad, on 03/02/2008 09:32

"I think a well thought out minor ailments scheme, that is not open to abuse, will be one of the single biggest steps forward for patients and primary care. The benefits will far outweigh the costs of such a national servic"

How scary is the threatened flu pandemic?

Posted by Ken Sims, on 24/01/2008 16:56

"With the serious results of wholly unfounded fears raised about the safety of the MMR vaccines in mind, it is hardly surprising that no one wants to raise potential panic in advance of a possibly lethal flu epidemi"

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